MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Wol + Med, M. Padron, MD, R.Helsten, MD, L. Miner, DC and G. Eubanks, OTR 2436 IH- 35 East South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-7407-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 American Zurich Ins. Co. c/o Zurich c/o Flahive 505 W. 12th Austin TX 78701	Date of Injury: Employer's Name: Patterson UTI Energy, Inc. Insurance Carrier's No.: 2230099885

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
6/4/02	6/4/02	99213, J1885	$144.00	$144.00
8/14/02	9/7/02	99213 x 2	$19.20	$19.20
9/9/02	9/27/02	97545-WH x 2 x 5	$102.40	$102.40
9/9/02	9/27/02	97546-WH x 26	$266.24	$266.24
8/29/02	8/29/02	97750	$100.00	$100.00
			TOTAL DUE:	$631.84

PART III: REQUESTOR'S POSITION SUMMARY

6/27/03: "Our Position: Date of service 6/4/02, the carrier failed to respond to our initial request and reconsideration. We feel the carrier has failed to comply with Rule 133.304. Medical Payments and Denials…reimbursement for a bill at a fair and reasonable…DOS..denied payment in full citing payment exception code "C, T, F." These denials are incorrect…The MAR for these charges was not paid…An insurance carrier shall treat a request for reconsideration as an incomplete medical bill…"

PART IV: RESPONDENT'S POSITION SUMMARY

6/30/03: "Summary of Carrier's Position: This dispute involves DOS from 6/4/02 through 8/29/03…Carrier reduced the billed charges to MAR then subtracted an amount based on the contract between the carrier and the provider. The one exception is DOS 6/4/02. The provider supplies no proof that this bill was sent to or received by the carrier…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 99213 and J1885, DOS 6/4/02, did not have any EOB attached. The requestor provided convincing evidence according to 133.307 (e)(2)(B) that the HCFA's were submitted for reimbursement to the respondent, as the other DOS were submitted according to Rule 133.304. Reimbursement recommended per the MFG /MAR, for the office visit and injection, $48.00 and $96.00 = **$144.00 due.**
- CPT Code 99213 for DOS 8/14/02 and 9/7/02 were denied "C – Negotiated Contract Price, F – Fee Guidelines MAR Reduction, and T- Treatment Guidelines." The respondent did not provide a copy of the mentioned 'C -contract' for an amount for reduction of the bill, the 'T - treatment guidelines' denial was no longer in effect due to the TWCC Advisory 2002-11 and the 'F –Fee Guideline MAR is $48.00. Therefore additional amount of ($48.00 - $38.40 paid previously = $9.60 x 2 **) $19.20 is due.**

- CPT Codes 97545-WH and 97546-WH for DOS 9/9/02 through 9/27/02 were denied "C – Negotiated Contract Price, F – Fee Guidelines MAR Reduction, and T- Treatment Guidelines." Again, the respondent did not provide a copy of the mentioned 'C -contract' for an amount for reduction of the bill, the 'T - treatment guidelines' denial was no longer in effect due to the TWCC Advisory 2002-11 and the 'F –Fee Guideline MAR for work hardening, non-CARF according to MFG/MGR (II)(C) and (E) is ($64.00 x 20% (less $12.80 =) $51.20 per hour.

  97545-WH = 2 units therefore = $51.20 x 2 = $102.40= 1 day. **97546-**WH = $51.20 x 26 =$1331.20

  $102.40 x 5 days = $512.00 Less amount paid : -1064.96

  Less amount previously paid to provider -$409.10 Total amount due : **$266.24**

  Total amount due: **$102.90**

- CPT Code 97750 (x 8 units) for DOS 8/29/02 was denied "C – Negotiated Contract Price, F – Fee Guidelines MAR Reduction." The respondent did not provide a signed contract. Reimbursement according to the MFG descriptor, Physical performance test or measurement with written report @$43.00 per each unit (8 units x $43.00 = $344.00 less amount previously paid - $244.00 =) **$100.00 due**.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $631.84. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Name	4/15/05 Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____